PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10680

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mos., 9 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 yr., 11 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)

Street No. Johnsontown P.O. Box #28
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: BAKER - ANNIE ELIZABETH (ELIZA)

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

B.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1396

8. AGE: Years: 49 | Months: unknown | Days: | If less than one day: --- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: Joseph Baker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Smith
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-4-45 (month) (day) (year)

Cemetery or crematory: Mogothy Cemty

Location: Jacobville Md. A.A. Co.

18. Funeral director: William A. Jackson

Address: 916 Penn ave. Balto. Md.

19. 11/3 (Date rec'd by registrar) 1945 E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 1945, at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22 1943, to Nov. 2 1945 and that I last saw her alive on November 2 1945

	DURATION
Immediate cause of death: General Paresis	Known to us since 11/30/43
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 11/2/45

9340

Baker - Annie Elizabeth (Eliza)
Anne Arundel County
Admitted - July 9, 1945

Died - November 2, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-7

10681

CERTIFICATE OF DEATH

★ Reg. Diat. No. 20 -

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrill Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. Ar
City or town: Gambrill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: John Zachariah Baldwin

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband ~~or wife~~: Anna Julia Baldwin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 11. 1856

8. AGE: Years	Months	Days	If less than one day
89			hrs. min.

9. Birthplace: Bowie P.G. Co.
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Farmer

FATHER
12. Name: Wm Edwin Baldwin
13. Birthplace: P.G. Co.

MOTHER
14. Maiden name: Mary Brady
15. Birthplace: Unknown

16. Informant: Mrs Melba Beck
Address: Gambrill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 23 1945 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: White Marsh

18. Funeral director: P.C. Saulsbury & Son
Address: Glenville Md.

19. Nov 21 1945 (Date rec'd by registrar) Carrie J. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 18 1945 to Nov. 19 1945 and that I last saw him alive on Nov. 18 1945

Immediate cause of death	DURATION
Acute myocardial failure	
Due to: arteriosclerosis -	
Due to: senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson M.D. M. D. or other
Address: Colton Md. Date signed 11/26/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (H) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

10682

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

198 Prince Geo St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 198 Prince Geo

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laura Virginia Basil

3. (b) Social Security Number Nov. 15 4 am

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife John Basil

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 15 - 1869

8. AGE:	Years	Months	Days	If less than one day
	76	2		..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Home Work

11. Industry or business

FATHER 12. Name James H. Vansant

13. Birthplace Balto md

MOTHER 14. Maiden name Mary E Kimball

15. Birthplace Baltimore, Md

16. Informant John Leslie Basil

Address 8 North Cherry Grove Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 45 (month) (day) (year)

Cemetery or crematory St Annes

Location Annapolis Md

18. Funeral director B L Hopkins

Address Annapolis Md

19. Nov. 16 19 45 (Date rec'd by registrar) O'Donnell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 19 45, at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 45, to Nov 15 19 45

and that I last saw h alive on Nov 14 19 45

Immediate cause of death	DURATION
Myocarditis + Myocardial Insufficiency	Several years
Due to arteriosclerosis	Several years
Due to	
Other conditions Hypertension	Several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boyd M. D. or other

Address Annapolis Md Date signed 11-16-45

10683

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County aa
City or town Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County aa
City or town Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary E. Bamford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife James H. Bamford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1 — 1851

8. AGE: Years 94 | Months 9 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James Wells
13. Birthplace Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Florence V. Wilson
Address Edgewater Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3/45 (month) (day) (year)
Cemetery or crematory Episcopal
Location Owensville Md

18. Funeral director B. F. Hopkins
Address Annapolis Md

19. Nov. 3, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1945, at 3.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1935, to Nov 1 1945, and that I last saw h. alive on Oct. 30 1945

Immediate cause of death Myocarditis + Myocardial Insufficiency (Ch)

DURATION: 10 Years

Due to

Due to

Other conditions Chronic Cystitis

DURATION: chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Boarman M. D. or other
Address Annapolis Md Date signed 11-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10684

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
55 Spa Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 55 Spa Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: William Herbert Booth

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Amanda Booth
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 15, 1890

8. AGE:	Years	Months	Days	If less than one day
	55			....hrs. ....min.

9. Birthplace: Calvert Co. Maryland (Town, county, and state)
10. Usual occupation: General Utility
11. Indusfry or business: None

FATHER
12. Name: William Booth
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden name: Rachel Gardiner
15. Birthplace: Calvert Co. Maryland

16. Informant: Mrs Amanda Booth
Address: 55 Spa road Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/ 23/45 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Nov 23 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19, 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/1/45 19.... to 11/19/45 19.... and that I last saw h... alive on Nov 14, 1945 19....

Immediate cause of death	DURATION
Pulmonary Hemorrhage	2 hours
Due to: Tuberculosis Pulmonary	Sev 8 1/2 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis Md. Date signed: Nov 23 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

10685

Reg. Dist. No. 81.21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: No
How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Monte Ellis Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Catherine Brandenburgh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Widowed

6.(b) Name of husband or wife: Stewart Hussey Brandenburgh
Record - age 64
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug. 9 1861

8. AGE: Years	Months	Days	If less than one day
84	3	29	hrs. min.

9. Birthplace: Johnsville - Frederick Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Kin Saylor
13. Birthplace: Frederick County
MOTHER 14. Maiden name: Margaret Hoffman
15. Birthplace: Frederick County
16. Informant: Wilbur Stewart Brandenburgh
Address: Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 11 - 1945 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: New Windsor Manchester Road
18. Funeral director: D. D. Hartzler & Sons
Address: Union Bridge & New Windsor Md.
19. Nov. 10, 1945 (Date rec'd by registrar) J. Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1945 at 11.35 P.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945, to Nov. 8, 1945
and that I last saw h... alive on November 8, 1945

Immediate cause of death	DURATION
Acute dilatation of the	Few hours
Due to, Heart	
Due to, Coronary Thrombosis	
Other conditions, Arteriosclerotic	
Cardio-Vascular Disease	7 Years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert W. Lederer M.D.
M. D. or other
Address: Annapolis Md. Date signed 11-8-45

10686

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Pasadena, Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Pasadena, R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fort Smallwood Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bertha N. Breighner

3.(b) Social Security Number: 214-22-7133

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Francis A Breightner
6.(c) If alive, give age: 18 years
7. Birth date of deceased (mo., day, yr.): May 8, 1923.

8. AGE: Years	Months	Days	If less than one day
22	5	22	....hrs. ....min.

9. Birthplace: Anne Arundel County (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: own Home

FATHER
12. Name: Oliver S. Duvall
13. Birthplace: Anne Arundel County, Md

MOTHER
14. Maiden name: Laura V. Watts
15. Birthplace: Glen Burnie, Md.

16. Informant: Mrs. Oliver S. Duvall
Address: Pasadena, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 4, 1945 (month) (day) (year)
Cemetery or crematory: Magothy Church Yard
Location: Jacobsville A.A.Co. Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 11-3 (Date rec'd by registrar) 19 45 L. A. O'Brien Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 19 45 at 10.40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 19 45 to Nov 1 19 45 and that I last saw h alive on Oct 31 19 45

Immediate cause of death	DURATION
Coronary T.B.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel Rubin M. D. or other
Address: 203 Baltimore ave Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10687

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: U.S. Naval Hospital Annapolis
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 179 Prince George Street
(If rural, give LOCATION)
2.(a) If veteran, name war: 2

3.(a) FULL NAME: Broach John Cozine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Dorothy M. Broach
6.(c) If alive, give age: 30 years
7. Birth date of deceased (mo., day, yr.): July 29, 1904

8. AGE: Years	Months	Days	If less than one day
41	3	13	..... hrs. ..... min.

9. Birthplace: New Orleans Louisiana (Town, county, and state)
10. Usual occupation: Naval Officer
11. Industry or business

FATHER
12. Name: John May Broach
13. Birthplace: Mississippi

MOTHER
14. Maiden name: Lily Garfield Cozine
15. Birthplace: Lexington, Kentucky

16. Informant: Condr. Claude H. Broach USN (Brother)
Address: Washington, D.C.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov 14/45 (month) (day) (year)
Cemetery or crematory: Nat Cemetery
Location: Annapolis Md
18. Funeral director: B E Hopkins
Address: Annapolis Md
19. Nov. 13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 November 1945, at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 November 1945, to 11 November 1945 and that I last saw h[illegible] alive on 11 November 1945.

Immediate cause of death	DURATION
Coronary Thrombosis	1 hour
Due to: Coronary Arteriosclerosis	unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: Coronary Thrombosis, Coronary Arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A. Barthel Lt (MC) USNR
M. D. or other
Address: U.S. Naval Hospital Annapolis, Maryland
Date signed: 11/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Klaware

Evidence for the change of age is shown on Film # G 99 11/21/45

10688

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:
831 Spa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 831 Spa Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Georgia Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: John W. Brown,

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 28, ~~1881~~ 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
63	8			

9. Birthplace: Shady Side, Md. A.A.Co.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: William Molden

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Bettie?

MOTHER — 15. Birthplace: Md.

16. Informant: Wilmer Alton

Address: 831 Spar Road Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14, 1945 (month) (day) (year)

Cemetery or crematory: Hopes Chapel

Location: Edge Water, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis Md.

19. Nov. 13 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 19 45 to Nov 11 19 45

and that I last saw h[er] alive on Nov 10 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days.
Due to: Generalized arteriosclerosis	
Due to: Hypertension	
Other conditions: Chr. Nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: M. T. Klaware, M.D. (M. D. or other)

Address: 31 Southgate Ave. Date signed 11/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

10689

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anundel Anne Arundel County
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anundel anne
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 Calvert Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Stella Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colred	Married

B.(b) Name of husband or wife Richard Brown
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) February 14. 1881

8. AGE: Years	Months	Days	If less than one day
64	8	23	hrs. min.

9. Birthplace Annapolis Maryland (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name Albert Henson
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah Doesey
15. Birthplace Maryland
16. Informant Richard Brown
Address 17 Calvert St Annapolis md
17. Burial (Burial, cremation, or removal. Which?) Date thereof November 11 1945 (month) (day) (year)
Cemetery or crematory Brew Hill cemetery.
Location Annapolis Maryland
18. Funeral director Joseph a. Lively Funeral Home
Address 66 West Dave St. Baltimore Maryland
19. Nov. 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1945 at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1945 to November 6 1945 and that I last saw h alive on 19
Immediate cause of death Carcinoma Stomach

	DURATION
Due to Carcinoma Stomach	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Herbert L. Johnson M. D. or other
Address 45 Northwest Street Date signed 11/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10690

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 year, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1313 Madison Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: BROWN - VIOLA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1917

8. AGE: Years: 28 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER — 12. Name: Spencer Brown
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lena Person
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1945 (month) (day) (year)

Cemetery or crematory: Pleasant Shade

Location: NewPort News, Virginia

18. Funeral director: Van P. Gilmore

Address: NewPort News, Virginia

19. Nov 15 1945 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1945 at 7:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3 1944, to Nov. 14 1945 and that I last saw her alive on November 14 1945

Immediate cause of death	DURATION
Status Epilepticus	Known to us since 11/12/45
Due to: ---	
Due to: ---	
Other conditions: Schizophrenia	Known to us since 11/3/44

(Include pregnancy within 3 months of death)

Major findings of operations: --- Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Hal J. Strudwick M. D. or other

Address: Crownsville, Maryland Date signed: 11/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Purvis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-D)

CERTIFICATE OF DEATH

★ 10621 Reg. Diat. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: 833 Spa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 833 Spa Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William H. Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Julia A. Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1861

8. AGE: Years	Months	Days	If less than one day
84	6		..... hrs. ..... min.

9. Birthplace: West River A.A.Co. Md. (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Elizabeth Randall

MOTHER — 15. Birthplace: Md.

16. Informant: William E. Brown

Address: 60 Cathedral St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 13, 1945 (month) (day) (year)

Cemetery or crematory: Brewer Wild

Location: Annapolis, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md.

19. Nov. 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10, 1945, at 3:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1945, to Nov 10 1945

and that I last saw him alive on Nov 9 1945

	DURATION
Immediate cause of death: Cardio Vascular Failure	Several weeks
Due to: Cr. Mitral Regurgitation & Myocarditis	Several years
Due to: Arterio Sclerosis & Cr Nephritis	Several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other

Address: Annapolis Md. Date signed 11/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10692

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo G Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, institution, or street address where death occurred:
Rock Avenue near Bldg 230
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5315 Liberty Heights Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: Lloyd M. Bunting

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude R. Bunting
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): September 16, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	23	-- hrs. -- min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Passenger Agent
11. Industry or business: B & O Railroad

FATHER
12. Name: Lloyd Bunting
13. Birthplace: Virginia

MOTHER
14. Maiden name: Martha ~~Mebbber~~ Parker
15. Birthplace: North Carolina

16. Informant: Mrs. Gertrude Bunting
Address: 5313 Liberty Heights Ave, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 12 45 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetary
Location: Baltimore, Md.

18. Funeral director: D. Willis Lamoreaux
Address: 4510 Liberty Heights Ave, Balto., Md.

19. 11-10 1945 Ft. Meade U.S. Registrar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 November 1945, at 4:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~XXX~~ only after death 19--, to 8 Nov 1945 and that I last saw him alive ~~XX~~ at no time 19--

Immediate cause of death	DURATION
head injuries, fractured ribs with puncture of lungs	immediate
Due to: Having been struck by a motor vehicle	immediate
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. ----
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8 Nov 45
Where did injury occur? Ft Geo G Meade, (City or town) Md. (County) A.A. (State) Md.
Injured at home, farm, industry, public place (where?): Military Post
Means of injury: Struck by motor Injured at work? Yes

23. SIGNATURE: James H. Mundhenk, Capt. M.C. M. D. or other
Address: Ft Geo G Meade, Md. Date signed: 11 Nov 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10693

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 6 College Ave. Annapolis Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6 College Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME Robert Burns III

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1945

8. AGE: Years | Months | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Annapolis Md. A.A. Co.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Robert Burns
13. Birthplace: Memphis Tenn.

MOTHER
14. Maiden name: Bessie Jordan
15. Birthplace: Charleston S.C.

16. Informant: Robert Burns Sr.
Address: 6 College Ave Annapolis Md.

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 11 | 24 | 45 (month) (day) (year)
Cemetery or crematory: Brewer Hiel Cemetery
Location: West St. Balto. Md.

18. Funeral director: Mrs Chas. Clayton Hicks
Address: 45 Northwest St Annapolis Md.

19. Nov. 24 1945 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21, 1945 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated, ~~last attended deceased from~~ —
Post mortem Examination
~~and that I last saw him alive on~~ Nov. 21 1945

	DURATION
Immediate cause of death: Convulsion	sudden
Due to: Intestinal indigestion	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Clatt M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 11-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

10694

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Oakley
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: BUTLER - JOSEPH LOUIS

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): August 1, 1935

8. AGE:

Years	Months	Days	If less than one day
10	3	26	----- hrs. ----- min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ---

FATHER
12. Name: Joseph Garvy
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Pearl E. Butler
15. Birthplace: Maryland (?)

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 29, 1945
(month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Bushwood, St. Mary's County

18. Funeral director: W. C. Mattingly Sons
Address: Leonardtown, Maryland

19. (Date rec'd by registrar) 1945 E. Z. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 19 45 at 9:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 19 45 to Nov. 27 19 45 and that I last saw him alive on November 27 19 45

Immediate cause of death	DURATION
Juvenile General Paresis (Congenital)	congenital
Due to: ------	
Due to: ------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: ------
Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ------
Accident, suicide, or homicide: ---------- Date of: ---------
Where did injury occur? ----------
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Herbert J. Mitchell M. D.
M. D. or other
Address: Crownsville, Maryland Date signed: 11/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

VS A15

10695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Richard H. Cadle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah C Cadle
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 30 - 1864

8. AGE:

Years	Months	Days	If less than one day
81	1	26	..... hrs. ..... min.

9. Birthplace: A A Co Md (Town, county, and state)
10. Usual occupation: Ret Carpenter
11. Industry or business

FATHER
12. Name: John Cadle
13. Birthplace: A A Co Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Sarah C. Cadle
Address: Edgewater A A Co Md
17. Burial, cremation, or removal. Which?: Burial — Date thereof: Nov 28 - 1945 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md
18. Funeral director: John W. Taylor & Son
Address: Annapolis Md.
19. Nov. 28 1945 (Date rec'd by registrar) — Wm. J. French, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/21 19 44, to Nov 26 19 45
and that I last saw h.. alive on 11/26 19 45

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr.
Due to: arteriosclerotic cardio vascular renal disease	20 yrs.
Due to:	
Other conditions: hypertrophy prostate & urinary retention & pleuro pneumonia (Include pregnancy within 3 months of death)	10 days

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Bowie Md M. D. or other
Address: Annapolis Md Date signed: 1/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11507 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 min.
Hospital, institution, or street address where death occurred:
703 Maple Rd.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. Co.
City or town: Halethorpe - Rosemont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3844 Pa. Ave. Baltimore 27
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: James Frank Carr

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Helen E. Carr. (nee Brown) 6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.): April 2, 1882

8. AGE: Years	Months	Days	If less than one day
63	7	11	...hrs. ...min.

9. Birthplace: Aberdeen, Md. (Town, county, and state)

10. Usual occupation: Ship Joiner

11. Industry or business: U.S. Coast Guard Yd. Curtis Bay Depot

FATHER — 12. Name: Oshar Carr

13. Birthplace: Md.

MOTHER — 14. Maiden name: Don't Know

15. Birthplace: Md.

16. Informant: Mrs. Helen E. Carr (Wife)
Address: 2844 Pa. Ave. Rosemont 27, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: A. A. Co., Md.

18. Funeral director: P. Howard Evans
Address: 1405 S. Charles St. Balto. 30, Md.

19. 11-14-1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13, 1945, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 8 - 1945, to Nov. 13 - 1945
and that I last saw h... alive on Nov. 13 - 1945

Immediate cause of death: Cardio-Vascular Disease — DURATION: 2 days

Due to: — DURATION:

Due to: — DURATION:

Other conditions: Grippe — DURATION: 5 days

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury — Injured at work?

23. SIGNATURE: Edw. L. Ball Jr. M.D. (M. D. or other)
Address: Linthicum — Date signed: 11-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

10696

P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs.

Hospital, Institution, or street address where death occurred:

104 - 4th Ave - S.W.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town Same

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Solomon James Caskey

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Agatha V. Caskey

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 22 - 1885

8. AGE:	Years	Months	Days	If less than one day
	60	5	18	..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Inspector

11. Industry or business Health Dept. (State)

FATHER 12. Name Solomon Caskey

13. Birthplace ? Baltimore

MOTHER 14. Maiden name Amelia Wooes

15. Birthplace Baltimore

16. Informant Mrs. Agatha Caskey

Address Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12, 1945 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Brooklyn Md.

18. Funeral director Wm. J. Tickner & Son

Address Balto. Md.

19. 11/12 1945 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945, at 6 Ft. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1940, to Nov. 10 1945 and that I last saw him alive on Nov. 10 1945

Immediate cause of death	DURATION
Cardiac - Vascular Disease	7 yrs.
Due to	
Due to	
Other conditions Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Bace Jr. M.D. M. D. or other

Address Linthicum Date signed 11-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10697

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
5 Calvert Court
How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5 Calvert Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Dora Clark

3.(b) Social Security Number: 213-16-4620

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: George Melvin Clark
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 20, 1914

8. AGE: Years	Months	Days	If less than one day
31	I	1	____ hrs. ____ min.

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: None

FATHER
12. Name: Joseph Johnson
13. Birthplace: Annapolis Md. A, A. Co.

MOTHER
14. Maiden name: Frances Johnson
15. Birthplace: Annapolis Md.

16. Informant: George Melvin Clark
Address: 5 Calvert Court Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/45 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. extd.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Nov 14 1945 (Date rec'd by registrar)
W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 12 1945, at 12 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h ____ alive on ____ 19____

Immediate cause of death	DURATION
Cerebral Apoplexy	Hours
Due to: Epileptic form Seizures	Several yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Helen Purcell M. D. or other
Address: Annapolis Md. Date signed 11/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10698

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? September 14, 1945

Hospital, institution, or street address where death occurred:

Maryland House of Correction, Hosp.

How long in hospital or institution? from 11/3/ to 11/5/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 Wineow St

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: COLEMAN, Albert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): October 31st, 1906

8. AGE: Years	Months	Days	If less than one day
39	0	5	....hrs. ....min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Md. House of Correction

Address: Jessups, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 1945 (month) (day) (year)

Cemetery or crematory: Cherry Hill Cemetery

Location: Jessups, Md.

18. Funeral director: H. L. Collins

Address: Jessups, Md.

19. Nov 19 1945 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5th, 1945 at 5.45 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/3/45 to 11/5/45 and that I last saw him alive on 11/5/45

Immediate cause of death	DURATION
Paralysis of respiration.	1/2 hr.
Due to: Cerebro-spinal syphilis	unknown
Due to: With vascular thrombosis, cerebral	48 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations

Date of op.:

Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: John A Clark M.D. (M. D. or other)

Address: Jessups, Maryland Date signed: 11/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10699

Reg. Diat. No. 195 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 8 mos, 25 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 year, 8 mos, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Jessup Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Guilford.
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3.(a) FULL NAME: COLEMAN - MABEL

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1926

8. AGE: Years: 19 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Student

11. Industry or business: -----

FATHER
12. Name: Jacob Coleman
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Moore
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 23, 1945 (month) (day) (year)
Cemetery or crematory: Gilford Baptist Cemetery
Location: Colesville, Howard County

18. Funeral director: W. C. White Co.
Address: Laurel, Maryland

19. 11/23/45 (Date rec'd by registrar) 19.. Frank Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24 1944 to Nov. 19 1945 and that I last saw her alive on November 19 1945

Immediate cause of death: Lung Tuberculosis — DURATION: Known to us since 6/19/44
Due to: -------
Due to: -------
Other conditions: Schizophrenia — Known to us since Feb.1944
(Include pregnancy within 3 months of death)
Major findings of operations: --------
Date of op.: -----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -----
Where did injury occur? ---------- (City or town) (County) ----- (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Albert J. Winstrode M. D. or other
Address: Crownsville, Maryland Date signed: 11/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-21)

CERTIFICATE OF DEATH

10700

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Emergency Hospital Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A.A.
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Mary Agnes Collins

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: James Collins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 10 1892

8. AGE:

Years	Months	Days	If less than one day
53	3	0	— hrs. — min.

9. Birthplace: Balto Md (Town, county, and state)
10. Usual occupation: Stone wife
11. Industry or business:
12. FATHER Name: Frank H. Mogereth
13. Birthplace: Balt
14. MOTHER Maiden name: Catherine E. Lann
15. Birthplace: Germany
16. Informant: James Collins
Address: Mayo Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 13 1945 (month) (day) (year)
Cemetery or crematory: St Mary Cem.
Location: Annapolis
18. Funeral director: D. G. Hardesty & Son
Address: Galesville Md.
19. Nov 12 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1945, at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945, to November 10, 1945
and that I last saw h... alive on Nov. 10, 1945

Immediate cause of death	DURATION
Uremia	2 days
Due to: Chronic Glomerular Nephritis	Since 1944
Due to:	
Other conditions: Arteriosclerotic-Cardio Vascular Disease (Include pregnancy within 3 months of death)	2 yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

If VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert H. Anderson M.D.
M. D. or other
Address: Annapolis, Md. Date signed: 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10701

CERTIFICATE OF DEATH

Reg. Diat. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 7 months, 13 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 year, 7 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Churchton (If outside city or town limits, write RURAL and give nearest town)
Street No. ——— (If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: COOK - MARIE BROWN (McCall)

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): December 14, 1904

8. AGE: Years	Months	Days	If less than one day
40	11	9	——— hrs. ——— min.

9. Birthplace: Churchton, Anne Arundel Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ———

FATHER
12. Name: Benjamin Brown
13. Birthplace: Churchton, Maryland

MOTHER
14. Maiden name: Grace Gross
15. Birthplace: Churchton, Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1945 (month) (day) (year)
Cemetery or crematory: Churchton Cemetery
Location: Churchton, Maryland

18. Funeral director: T. A. Hardesty & Son
Address: Galesville, Maryland

19. Nov. 24 19 45 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 19 45 at 1:55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 19 44 to Nov. 23 19 45 and that I last saw her alive on November 23 19 45

Immediate cause of death: General Paresis — DURATION: Known to us since 4/25/44
Due to: ———
Due to: ———
Other conditions: ———
(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Herbert Hardesty M. D. or other
Address: Crownsville, Maryland Date signed: 11/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10702

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs, 6 mos, 5 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 15 yrs, 6 mos, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: unknown (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3.(a) FULL NAME: DOE - MARY (Della Strothers)

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1885 (?)

8. AGE: Years	Months	Days	If less than one day
60 ?	unknown		---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business: -------

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/16/45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt. Hospital

Address: Crownsville Md

19. Nov 16 1945 (Date rec'd by registrar) E. Joyce Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1945 at 6:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1930 to Nov. 6 1945 and that I last saw her alive on November 6 1945

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 3/21/34
Due to: -------	
Due to: -------	
Other conditions: Mental Deficiency Without Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: ----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 11/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10703

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs, 9 mos, 15 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 11 yrs, 9 mos, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick (If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Klinehart Alley (If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: DORSEY - BEATRICE

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	separated

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): May 6, 1907

8. AGE: Years	Months	Days	If less than one day
38	6	10	---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ----

FATHER — 12. Name: Abe Dorsey

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Grant

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof 11-19-1945 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery Simpsons Chapel

Location: New Market Frederick, Md.

18. Funeral director: M. R. Etchison & Son

Address: Frederick, Md.

19. 11/16/45 (Date rec'd by registrar) 19---- E Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1945, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1934, to Nov. 16 1945 and that I last saw her alive on November 16 1945

Immediate cause of death	DURATION
Lung Tuberculosis	Known to us since 9/4/45
Due to: -------	
Due to: -------	
Other conditions: Schizophrenia	Known to us since 1/31/34

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: ----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): --------

Means of injury: -------- Injured at work? -----

23. SIGNATURE: Albert J. Whitcomb M. D. or other

Address: Crownsville, Maryland Date signed: 11/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

16704

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Emergency Hospital Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A A.

City or town: Edmunston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles E. Evans

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 20. 1869

8. AGE: Years: 76 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Edmunston Md (Town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER
12. Name: Hiram Peter Evans
13. Birthplace: Md

MOTHER
14. Maiden name: Margaret A. Evans
15. Birthplace: Deal Island Md

16. Informant: John W. Howes
Address: Edmunston Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov (month) 2 (day) 1945 (year)
Cemetery or crematory: Leatherbury Emp
Location: Deale Md

18. Funeral director: E. A. Saulsbury
Address: Galesville Md

19. Nov. 30 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 1945, at 12.55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 28 1945, to Nov 29 1945
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardio Vascular Failure	24 hrs.
Due to: Uraemia Death	24 hrs.
Due to: Cr. Hypertrophied Prostate	several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Elmer Purvis M. D. or other

Address: Annapolis Md Date signed 11/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d.)

CERTIFICATE OF DEATH

11510

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Anne Arundel

City or town Jessup

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montevideo

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Jessup

(If outside city or town limits, write RURAL and give nearest town)

Street No. Montevideo

(If rural, give LOCATION)

2.(a) If veteran, name war and

3.(a) FULL NAME George Washington Fritts

3.(b) Social Security Number 213-22-2208

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21 1882

8. AGE: Years	Months	Days	If less than one day
63	7	24	..... hrs. ..... min.

9. Birthplace Shenandoah Virginia
(Town, county, and state)

10. Usual occupation House Painter

11. Industry or business

FATHER 12. Name John A. Fritts

13. Birthplace Va.

MOTHER 14. Maiden name Caird Osborne

15. Birthplace Va.

16. Informant Goldie C. Fritts

Address 63 Workman Ave, Glen Green N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 17 1945 (month) (day) (year)

Cemetery or ~~crematory~~ Meadow Ridge Mem. Park

Location Arnold Md.

18. Funeral director A. Phillip Waldron

Address Laurel Md.

19. 11/16/45 (Date rec'd by registrar) 19.....

Clara Hasler Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1945, at 10:30 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to Nov 14 1945 and that I last saw h.. alive on Nov 14 1945

Immediate cause of death	DURATION
Bronchio-Pneumonia	10 da
Due to Myocardial insufficiency	1 week
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Brumbaugh M. D. or other

Address 609 Main St Elkridge Md. Date signed 11/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on G 99 11-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

10705

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Laurel – rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, Institution, or street address where death occurred:
District Training School
How long in hospital or institution? 13 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2006 Davison Ct. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Gordon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-19-22

8. AGE:	Years	Months	Days	If less than one day
23	22	10	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: inmate
11. Industry or business:

FATHER
12. Name: Robert Gordon
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary - -
15. Birthplace: Maryland

16. Informant: records of District Training School, Laurel, Md.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 24-45 (month) (day) (year)
Cemetery or crematory: District Training School
Location: Laurel Md. (Official)
18. Funeral director: Non (Superintendent Official)
Address: District Training School
19. Nov 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 19 45, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-41 19 to 11-22-45 19 and that I last saw him alive on 11-21-45 19

Immediate cause of death	DURATION
epilepsy	life
Due to: congenital organic brain disease	life
Due to:	
Other conditions: mental deficiency	life

(Include pregnancy within 3 months of death)

Major findings of operations:
none Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan M Drummond MD M. D. or other
Address: District Training Sch. Date signed 11-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10707

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 6 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore City
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 1219 Pennsylvania Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3.(a) FULL NAME: GRAHAM - RHODA

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years	Months	Days	If less than one day
76	unknown		--- hrs. --- min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Julia Edwards
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 5 1945 (month) (day) (year)

Cemetery or crematory: Laural

Location: Baltimore City

18. Funeral director: Mrs Katie R Williams

Address: 322 N Schroeder Street

19. 11/1 1945 E Z Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1945 at 10:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 1945 to Nov. 1 1945 and that I last saw her alive on November 1 1945

Immediate cause of death	DURATION
Chronic Myocarditis	Known to us since 9/26/45
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis	Known to us since 9/26/45

(Include pregnancy within 3 months of death) ----------

Major findings of operations: ----- Date of op. -----

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: -------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ------- Injured at work? ----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 11/1/45

VS A15

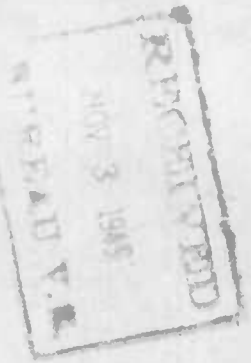
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9477

Graham - Rhoda
Baltimore City
Admitted - September 26, 1945

Died - November 1, 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

16706

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Regional Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: - PG

City or town: Laurel, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Laurel Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Henry J. GRAFF (R-2386234)

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 19, 1882

8. AGE: Years	Months	Days	If less than one day
62	11	23	..... hrs. - ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Soldier (Retired)

11. Industry or business: U.S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mabel Brown
Address: 314 Laurel Ave, Laurel, Md.

17. Transportation
(Burial, cremation, or removal. Which?)
Date thereof 11/3/45
(month) (day) (year)

Cemetery or crematory: Selby Funeral Home

Location: Laurel, Md.

18. Funeral director: Howard J. Blyth Jr.

Address: 4914 Belair Road

19. 4 November 19 45 Frank J. Tollison
(Date rec'd by registrar) FRANK J. TOLLISON CAP Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 November 19 45 at 9:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 November 19 45 to 3 November 19 45 and that I last saw him alive on 3 November 19 45

	DURATION
Immediate cause of death: Uremia	unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE: Samuel Stone
SAMUEL STONE, CAPT MC M. D.

Address: Regional Hospital Ft Meade Md Date signed: 6 Nov 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1860)

10708

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 5 hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Larry Griffin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	—

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1943

8. AGE: Years 2 | Months | Days | If less than one day hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thornton Griffin
13. Birthplace Arnold, Md.

MOTHER 14. Maiden name Agnes Watts
15. Birthplace Arnold, Md.

16. Informant Thornton Griffin
Address Arnold, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 1945 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location Arnold, Md.

18. Funeral director J. B. Johnson
Address Annapolis, Md.

19. Nov. 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1945 at 4 40 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination and that I last saw h~~im~~ ~~her~~ alive on Nov. 8 1945

Immediate cause of death	DURATION
Sub-dural Hemorrhage	
Due to Fall	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11-8-45
Where did injury occur? Arnold (City or town) A.E. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Fall - Struck head Injured at work?

23. SIGNATURE John M. Coffy M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 11-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10709

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 25 Monument St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Monument St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daisy Harris

3.(b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 1878

8. AGE: Years	Months	Days	If less than one day
67	10		... hrs. ... min.

9. Birthplace: Annapolis, Md. A.A.Co. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: John Harris

13. Birthplace: Md.

MOTHER 14. Maiden name: Eliza Giles

15. Birthplace: Md.

16. Informant: William Harris

Address: 25 Monument St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1945 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: J. B. Johnson

Address: Annapolis Md.

19 Nov. 18 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14, 1945, at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945, to Nov 14 1945 and that I last saw her alive on Nov 14, 1945

	DURATION
Immediate cause of death: Broncho Pneumonia	7 days
Due to	
Due to	
Other conditions: Arterio-Sclerosis, Hy[illegible] (Include pregnancy within 3 months of death)	1 year

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other

Address: [illegible] Date signed: 11/15/45

Dr. Clawans.

10710

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Wildrose Shore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Wildrose Shore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: [redacted] Matilda Harris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: S.H.Harris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	28	..... hrs. ..... min.

9. Birthplace: A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Henry Clay Galory
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Rebecca?
15. Birthplace: A.A.Co.

16. Informant: Charles E. Harris
Address: Wildrose Shore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1945 (month) (day) (year)
Cemetery or crematory: Hopes Chapel
Location: Edgewater, Md.
18. Funeral director: J.B.Johnson
Address: Annapolis, Md.

19. Dec 1 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1945 at 7:44 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Nov 29 1945 and that I last saw her alive on Nov 27 1945

	DURATION
Immediate cause of death: Chr. Myocarditis	
Due to: Senility	
Due to:	
Other conditions: Ca. Cataract Ulcer	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W K Clawans M.D. M. D. or other
Address: 3 Smithgate Ave. Date signed: 12/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10711

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs, 8 mos, 17 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 8 yrs, 8 mos, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Melwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. ------
(If rural, give LOCATION)
2.(a) If veteran, name war ------

3.(a) FULL NAME: HODGE - LOUISE

3.(b) Social Security Number ------

4. Sex: Female
5. Color or race: black
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: ------
6.(c) If alive, give age ---- years
7. Birth date of deceased (mo., day, yr.): 1908
8. AGE: Years: 37 Months: unknown Days: If less than one day ---- hrs. ---- min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ------
FATHER 12. Name: Joshua Hodge
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Alice Deacon
MOTHER 15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt. of Hospital
Address: Crownsville
19. 11-23-45 (Date rec'd by registrar) 1945 E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1945 at 11:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1937 to Nov. 20 1945 and that I last saw her alive on November 30 1945

	DURATION
Immediate cause of death: Lung Tuberculosis	Known to us since 9/22/38
Due to: ------	
Due to: ------	
Other conditions: Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	Known to us since 3/3/37

Major findings of operations: ------ Date of op. ------
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE: Fred V. Adams M. D. or other
Address: Crownsville, Maryland Date signed 11/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-L)

CERTIFICATE OF DEATH

10712

Reg. Dist. No. 39 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Laurel, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs.-
Hospital, Institution, or street address where death occurred:
District Training School
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Laurel,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Laurel-Fort Meade Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Briscoe Holmes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10/16/1894

8. AGE:

Years	Months	Days	If less than one day
51	1	-	hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Inmate

11. Industry or business: none

FATHER
12. Name: First name unknown Holmes
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mollie Briscoe
15. Birthplace: Washington, D.C.

16. Informant: D.T.S. Records
Address: District Tr. School, Laurel, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Nov. 20, 1945
(month) (day) (year)
Cemetery or crematory: Payne Cemetery
Location: 4640 Benning Rd. S.E. Wash. D.C.

18. Funeral director: Robert C. Campbell
Address: 423 4th Street, S.W.-Washington, D.C.

19. NOV 17 1945
(Date rec'd by registrar)
M. Quarles
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1945, at 8:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1/41 19.. to 11/16/45 19.. and that I last saw him alive on 11/15/45 19..

Immediate cause of death	DURATION
Carcinoma of stomach	3 yrs.
Due to	
Due to	
Other conditions: Mental deficiency, imbecile life level, generalized arteriosclerosis traumatic hernia of abdomen	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Glen M Drummond M.D.
M. D. or other
Address: D.T.S. Laurel Md. Date signed: 11-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Klauss

Evidence for the change of ageis shown on

G 99 12-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7360

CERTIFICATE OF DEATH

10713

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Ann Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

71 Larkin St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Ann Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 71 Larkin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Oliver Hopkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Eliza Hopkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	9	4	..... hrs. ..... min.

9. Birthplace Lothian, Md. A.A.Co. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Nick Hopkins

13. Birthplace Md.

MOTHER

14. Maiden name Katie ?

15. Birthplace Md.

16. Informant Eliza Hopkins

Address 71 Larkins St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24, 1945 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md.

19. Nov. 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21, 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1945, to Nov 21 1945

and that I last saw him alive on Nov 2 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sudden
Due to: Hypertension Cardio Vasc. Dis	Yrs.
Due to:	
Other conditions Treated by me for Pulmonary Tuberculosis	Sept 14 to 11/2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M.N. Edwards, M.D. M. D. or other

Address 31 Southgate Ave. Date signed 11/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10714

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Waugh Chapel (Odenton Md. R.F.D.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Odenton Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Waugh Chapel
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Johanna Margaret Howard,

3.(b) Social Security Number None

4. Sex	5. Color or race	5.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife James Samuel Howard
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 14, 1873

8. AGE: Years	Months	Days	If less than one day
72	4	24	hrs. ..... min.

9. Birthplace Stuttgard Germany
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business Own Home
FATHER 12. Name Jacob J. Mahle
13. Birthplace Germany
MOTHER 14. Maiden name Unknown
15. Birthplace Germany
16. Informant James S. Howard
Address Odenton, Md. R.F.D.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 8 1945 (month) (day) (year)
Cemetery or crematory Waugh Chapel
Location Waugh Chapel (Odenton, R.F.D. Md.)
18. Funeral director Thomas W. Pumphrey
Address Glen Burnie, Md.
19. Nov. 7 1945 (Date rec'd by registrar) Mae Allen Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5-45 19 ..... at 4 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12-45 to Nov 5-45 19 .....
and that I last saw h.. alive on Nov. 2-45 19 .....
Immediate cause of death Lobar Pneumonia — DURATION 3 days
Due to 6
Due to .....
Due to .....
Other conditions Cerebral Hemorrhage 1 wk.
(Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Wm. H. Lapp M.D.
M. D. or other
Address Glen Burnie Md. Date signed Nov 6 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10715

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred: Route 1 Odenton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Odenton Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Blanche C. Jacobs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Infant

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1945

8. AGE: Years | Months 1 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Severn, Md.
(Town, county and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Laurence M. Jacobs
13. Birthplace Arlington, Va.

MOTHER
14. Maiden name Cora W. Millard
15. Birthplace Scranton Pa.

16. Informant Laurence M. Jacobs
Address Odenton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19 1945 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Anne Arundel County, Md.

18. Funeral director Wm. Cook Inc.

Address 1217 St. Paul St.

19. Nov 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17- 45 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 17-45 19 to Nov 17- 45 19 and that I last saw h- alive on Nov 17-45 19

Immediate cause of death: Acute Bronchopneumonia — DURATION 1 Day

Due to: Infant seen by me only 15 minutes before its death.

Due to:

Other conditions: No medication given. This is my only connection with this case.
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy Results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address Odenton Md. Date signed Nov 17 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

10716

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs, 8 mos, 6 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 7 yrs, 8 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rocks
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMISON - JOHN A.

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Annie Noland Jamison,
Rocks, Harford Co., Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): July 4, 1861

8. AGE: Years	Months	Days	If less than one day
84	4	21	--- hrs. --- min.

9. Birthplace: Federal Hill, Maryland (Harford Co.)
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: John W. Jamison (?)
13. Birthplace: Maryland

MOTHER
14. Maiden name: Katie ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1945 (month) (day) (year)
Cemetery or crematory: St. James (colored)
Location: Federal Hill, Maryland

18. Funeral director: Martin G. Kurtz
Address: Jarrettsville, Maryland

19. 11-26-45 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1945 at 2:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1938 to Nov. 25 1945 and that I last saw him alive on November 25 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 3/19/38
Due to: ---	
Due to: ---	
Other conditions: Senile Psychosis - Paranoid Type (Include pregnancy within 3 months of death)	Known to us since 3/19/38

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert J. Winterode M. D. or other
Address: Crownsville, Maryland Date signed: 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10717

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 76 Conduit St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sophie A. Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Thomas Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 29 1877

8. AGE:	Years	Months	Days	If less than one day
	67	11	5	..... hrs. ..... min.

9. Birthplace ~~Arundel~~ New York
(Town, county, and state)
10. Usual occupation Home Wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Thomas Johnson
Address Annapolis Md.
17. Burial Date thereof Nov 6 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Marys
Location Annapolis Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.
19. Nov 5 1945
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to Nov 4, 2pm 1945 and that I last saw h... alive on Nov 4 1945

Immediate cause of death	DURATION
Myocarditis & Myocardial Degeneration (Chron)	when
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Bond M. D. or other
Address Annapolis Md Date signed 11-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 10718 P

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs, 11 mos, 6 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution 4 yrs, 11 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2212 McCulloh Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JONES - MARY ELIZABETH

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years	Months	Days	If less than one day
44	unknown		---- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER — 12. Name: Willie Richardson

FATHER — 13. Birthplace: Washington, D. C.

MOTHER — 14. Maiden name: Birdie Jones

MOTHER — 15. Birthplace: Washington, D. C.

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: George G. Kelson

Address: 1303 Presstman St., Balto., Md.

19. 11/20/45 (Date rec'd by registrar) R. D. Hedrick Registrar

3.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 19 45 at 4:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 19 41 to Nov. 18 19 45

and that I last saw h... er alive on November 18 19 45

Immediate cause of death: General Paresis — DURATION: Known to us since Dec. 1941

Due to: -------

Due to: -------

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings of operations: --------

Date of op. ----

Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of ---

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ---------- Injured at work? -----

23. SIGNATURE: Herbert Hinkleader, M. D. or other

Address: Crownsville, Maryland Date signed 11/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

CERTIFICATE OF DEATH

16719

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hrs.
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Jessup
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Kidwell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	S.

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Jan. 3 1944.

8. AGE: Years	Months	Days	If less than one day
1	10	21	... hrs. ... min.

9. Birthplace: Jessup - A.A. Md.
(Town, county, and state)
10. Usual occupation: Child.
11. Industry or business
FATHER 12. Name: William F. Kidwell
13. Birthplace: Upper Marlboro - Md.
MOTHER 14. Maiden name: Mary R. McKenzie
15. Birthplace: Upper Marlboro - Md.
16. Informant: William F. Kidwell
Address: Jwd Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov. 26 1945 (month) (day) (year)
Cemetery or crematory: Mt Carmel Cem
Location: Upper Marlboro.
18. Funeral director: K.E. Stansbury & Son
Address: Galesville Md.
19. Nov. 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-24. 1945 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-24 1945, to 11-24 1945
and that I last saw h... alive on 11-24. 1945

	DURATION
Immediate cause of death: Hemorrhages	24 hrs.
Due to: Hemophilia	birth
Due to: (Inherited.)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Elizabeth Peabody Trevett M.D.
M. D. or other
Address: 172 Green St. Annapolis Md. Date signed 11-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

10720 P

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war W

3. (a) FULL NAME Anna M Langheinrich

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1908

8. AGE: Years 37 | Months 9 | Days 14 | If less than one day hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Charles Langheinrich

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden name Mary Dorothea

MOTHER 15. Birthplace Baltimore Md

16. Informant Charles Langheinrich

Address Linthicum Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/45 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn Md

18. Funeral director Pullom Funeral Home

Address 124 E Pratt St

19. Nov. 8 1945 (Date rec'd by registrar) A V Pedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1938 to Nov. 7 1945 and that I last saw h alive on Nov. 7 1945

	DURATION
Immediate cause of death Epilepsy	30 yrs.
Due to	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr M.D. M. D. or other

Address Linthicum Date signed 11-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10721

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address (where death occurred): U.S. Naval Hospital, Annapolis
How long in hospital or institution?: 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Connecticut County:
City or town: Waterbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 44 Elmwood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Marggraff Frederick Charles Jr. | **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Ruth Marggraff
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 27 1905

8. AGE: Years: 40 | Months: 9 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Waterbury Connecticut
(Town, county, and state)

10. Usual occupation: Naval Officer

11. Industry or business:

FATHER
12. Name: Frederick C Marggraff
13. Birthplace: Waterbury Conn

MOTHER
14. Maiden name: Jennie Clark
15. Birthplace: Waterbury Conn

16. Informant: Ruth Marggraff
Address: 44 Elmwood Ave Waterbury Conn

17. Removal
(Burial, cremation, or removal. Which?) Date thereof: Nov 13/45
(month) (day) (year)
Cemetery or crematory: Riverside
Location: Waterbury Conn
18. Funeral director: B L Hopping
Address: Conn

19. Nov 13 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 November 1945, at 2:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 November 1945 to 16 November 1945
and that I last saw h... alive on 16 November 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 days
Due to: Cerebral Arteriosclerosis	unknown
Due to:	
Other conditions: Hypertensive Cardio Vascular Disease	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op...
Autopsy results: Cerebral Thrombosis, Cerebral Arteriosclerosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A. Barthel Lt (MC) USNR
M. D. or other
Address: U.S. Naval Hospital, Annapolis, Maryland Date signed: 11/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-a)

CERTIFICATE OF DEATH

10722

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5 St. Mary's
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude E. Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: Charles H. Martin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18- 1878

8. AGE: Years: 67 Months: 3 Days: 21 If less than one day: hrs. min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business:

FATHER
12. Name: Geo H. Davis
13. Birthplace: Balto Md

MOTHER
14. Maiden name: Mary A. Bivans
15. Birthplace: Balto Md.

16. Informant: Bernard J. Martin
Address: 5 St Mary's Ct

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12/45 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Annapolis Md

18. Funeral director: B E Hopkins
Address: Annapolis Md

19. Nov 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 1945, at 3 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31 1945 to Nov. 8 1945 and that I last saw h[er] alive on Nov. 8 1945

Immediate cause of death	DURATION
Auricular Fibrillation	2 years
Due to: Arterial Hypertension	Unknown
Due to: Cerebral arterio, sclerosis	1 year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Claffy M.D
Address: Annapolis Md M. D. or other
Date signed: 11-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10723

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown (If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: McGHEE - JOSEPH

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	blaqk	widower

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): April 23, 1880

8. AGE: Years	Months	Days	If less than one day
65	7	0	--- hrs. --- min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ---

FATHER
12. Name: Thomas McGhee
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Anne Richardson
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 29, 1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: Anne Arundel County

18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. Nov 29 1945 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 19 45 at 1:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 19 45 to Nov. 23 19 45 and that I last saw him alive on November 23 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: ---	
Due to: ---	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 11/19/45

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 11/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10724

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-C

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Igleharts

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Hours

Hospital, Institution, or street address where death occurred:

Igleharts

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Igleharts

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Girl Baby Mc Knew

3. (b) Social Security Number

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
F	W	single

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 24 1945

8. AGE:

Years	Months	Days	If less than one day
			11 hrs. ..... min.

9. Birthplace Igleharts (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Roland W Mc Knew

13. Birthplace Odenton. Md.

MOTHER

14. Maiden name Ruth A Downs

15. Birthplace a a Co Md

16. Informant Roland W Mc Knew

Address Igleharts. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26/45 (month) (day) (year)

Cemetery or crematory Baldwin memorial

Location Millersville Md

18. Funeral director B. L. Hopkins

Address Annapolis Md.

19. Nov 26 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1945 at 5-50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-24 1945 to 11-24 1945 and that I last saw h.er alive on 11-24-45 19

Immediate cause of death	DURATION
a teleatasis of lungs	
Due to aspiration of fecal matter	11 hrs.
Due to child was born ½ hour before my arrival at bedside	
Other conditions Was having with navel cord still connected.	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Rodler M.D. M. D. or other

Address 42 State Circle Annapolis Date signed 11-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

10725

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No.: 500 Grosvenor's Lane (If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: McROY - WALTER

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Lilly McRoy, 500 Grosvenor Lane, Bethesda 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): June 20, 1887 (1892?)

8. AGE: Years	Months	Days	If less than one day
53 ? 58 ?	4	22	--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ----

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Nelly ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 15, 1945 (month) (day) (year)
Cemetery or crematory: Lincoln Park
Location: Rockville, Maryland

18. Funeral director: Robert L. Snowden
Address: Rockville, Maryland

19. 11/13/46 (Date rec'd by registrar) E. Z. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 19 45 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26 19 45 to Nov. 12 19 45 and that I last saw him alive on Nov. 12 19 45

Immediate cause of death	DURATION
General Paresis	Known to us since 10/26/45
Due to: -------	
Due to: ------	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op.: -----
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: ----
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: ---------- Injured at work? ----

23. SIGNATURE: Robert L. Snowden M. D. or other
Address: Crownsville, Maryland Date signed: 11/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on Film No. G99 - 11/20/45

10726

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? –
Hospital, institution, or street address where death occurred: Regional Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Arkansas County: –
City or town: W. Helena
(If outside city or town limits, write RURAL and give nearest town)
Street No. 146 N. 4th Street
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Warren NUNN 18191678

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): November 18, 1920

8. AGE: Years	Months	Days	If less than one day
24 ~~25~~ 24	11	17	... hrs. – ... min.

9. Birthplace: Amity, Arkansas (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: US Army

FATHER
12. Name: Mr. Iveson F. Nunn
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/5/45 (month) (day) (year)
Cemetery or crematory: Benton Funeral Home
Location: Fordyce, Arkansas

18. Funeral director: Howard M. Blight Jr.
Address: 4914 Belair Road.

19. 5 November 1945 (Date rec'd by registrar) Frank J. Tollison FRANK J. TOLLISON CAPT Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 November 19 45 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 November 19 45 to 4 November 19 45 and that I last saw him alive on 4 November 19 45

Immediate cause of death	DURATION
Acute Cardiac decompensation and failure	3 days
Due to: Acute glomerulonephritis and intestitial pneumonia.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: – Injured at work? –

23. SIGNATURE: James H. Matthews
JAMES H. MATTHEWS, CAPT MC M. D. or Other
Address: Date signed:

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

10727

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Camp Meade Linthicum Hts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
Camp Meade Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A. Co.
City or town: Linthicum Hts. Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Camp Meade Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nellie Elizebeth Palmer

3. (b) Social Security Number

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Louis F. Palmer. Sr.
6.(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): March 17 1907
8. AGE: Years: 38 Months: 8 Days: 1 If less than one day: hrs. min.
9. Birthplace: Glen Rock. York Co. Penna. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: Wm. E. Mann.
FATHER 13. Birthplace: York Pa.
MOTHER 14. Maiden name: Lydia E Crone
MOTHER 15. Birthplace: York. Pa
16. Informant: Mr. Louis F. Palmer, Sr.
Address: Camp Meade Rd., Linthicum Hgts.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/21/45 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. Nov 19 1945 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1945 at 4.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1943, to Nov. 18 1945 and that I last saw h alive on Nov. 18 1945

	DURATION
Immediate cause of death: Cancer of Vertebra	1 yr.
Due to: Metastasis from breast	
which was removed.	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Bare M.D. (M. D. or other)
Address: Linthicum Date signed 11-18-45

10728

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 1909
Hospital, Institution, or street address where death occurred: Parole, Maryland
How long in hospital or institution? ———

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Neomi Parker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Earnest Parker
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 2, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	10	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: John Henry Sembly
13. Birthplace: Westriver, Maryland

MOTHER
14. Maiden name: Mary Emma Banks
15. Birthplace: Baltimore, Maryland

16. Informant: Earnest Parker
Address: Parole, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/13/45 (month) (day) (year)
Cemetery or crematory: Brewer's Hill
Location: West Street

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Nov. 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1945 at 7.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1942 to Nov 10 1945 and that I last saw h... alive on November 9 1945

	DURATION
Immediate cause of death: Generalized Carcinomatosis	1 yr.
Due to: Primary Carcinoma of Uterus(?)	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Biopsies at J.H.H. apparently confirmed. Date of op. Feb 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

28. SIGNATURE: M. J. Kleweno, Jr. M. D. or other
Address: 31 Southgate Av Date signed: 10/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10729

★ Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 99 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ardelia Eugenia Parse

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 7th 1945

8. AGE: Years | Months | Days | If less than one day: 10 hrs. 20 min.

9. Birthplace Annapolis Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Eugene Melvin Parse

13. Birthplace Ind.

MOTHER 14. Maiden name Alice V Esperitu

15. Birthplace Phila Pa.

16. Informant Eugene M. Parse

Address 99 Main St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 9th 1945 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director John M. Taylor & Son

Address Annapolis Md

19. Nov. 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1945 at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-7 1945 to 11-7 1945 and that I last saw h... alive on 11-7 1945

	DURATION
Immediate cause of death atelectasis	
prematurity	10 hrs
Due to prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Dadlez M.D. M. D. or other

Address 42 State Circle Annapolis Date signed 11-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10730

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 325 First St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Virginia Phillips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife James N. Phillips
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 5th 1883

8. AGE:

Years	Months	Days	If less than one day
62	4	29	..... hrs. ..... min.

9. Birthplace Eastport Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Frederick Heinbuch
13. Birthplace Germany
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant James N. Phillips
Address 325 First St. Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6th 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John W. Taylor & Son
Address Annapolis Md.
19. Nov 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1945, at 1 15 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 1945 to Nov 3 1945
and that I last saw h.... alive on November 1 1945
Immediate cause of death Coronary Occlusion
Attacks began 1st Aug 5/45 — Duration 3 months
Due to Arterial Hypertension — Duration Several yrs.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edwin Purvis M. D. or other
Address Annapolis Md. Date signed 11/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

10731

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred: 82 Clay St. Annapolis Md.
How long in hospital or institution? *****

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis -d.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 82 Clay St.
(If rural, give LOCATION)
2.(a) If veteran, name war: **********

3.(a) FULL NAME: Louise Pinkney

3.(b) Social Security Number: 219-12-3192

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: James Pinkney
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1906

8. AGE: Years	Months	Days	If less than one day
39	2	4	....hrs. ....min.

9. Birthplace: Lothian Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sallie Henson
15. Birthplace: A, A. Co. Md.

16. Informant: Annabell Johnson
Address: 75 Clay St Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 / 14 /45 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. extd.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Nov. 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10 1945 at 4.50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2 1945, to Nov 10 1945, and that I last saw h- alive on Nov 8 1945.

Immediate cause of death	DURATION
Stated Carcinomatosis	?
Due to: Carcinoma of uterus (Body)	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Recently operated upon at G. H. H. - Admitted from Baltimore Date of operation

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. F. Klaus M.D. (M. D. or other)
Address: 31 South Gate Av. Date signed 11/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10732

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: mmmm

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 614 N. Dallas Street
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: PLUMMER - LOUISE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Paul Plummer, 732 Dallas St., Baltimore 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE:	Years	Months	Days	If less than one day
	38	unknown		--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER — 12. Name: Jessie Davis
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Roddie Jigges
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Removal — Date thereof Nov. 4, 1945 11/3/45 (month) (day) (year)

Cemetery or crematory: Bostons

Location: South Hill, Virginia

18. Funeral director: Mrs. Robert Elliott
Address: 1129 N. Caroline St., Balto. Md.

19. Nov 1 1945 E.T. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 1945, at 6:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26 1945 to Nov. 1 1945 and that I last saw her alive on November 1 1945

Immediate cause of death	DURATION
Schizophrenic Exhaustion	
Due to: -------	
Due to: -------	
Other conditions: Schizophrenia - Hebephrenic Type (Include pregnancy within 3 months of death)	Known to us since 10/26/45

Major findings of operations: ------ Date of op. -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---------

Means of injury ------- Injured at work? -----

23. SIGNATURE: Herbert Stinebrook M. D. or other

Address: Crownsville, Maryland Date signed 11/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10733

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 169 King George St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Leonard B. Popham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Margaret Popham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 18, ~~1845~~ 1859

8. AGE:

Years	Months	Days	If less than one day
86	7	11	..... hrs. ..... min.

9. Birthplace Annapolis, Md (Town, county, and state)

10. Usual occupation retired watchman

11. Industry or business State House, Annapolis

FATHER 12. Name George Popham

13. Birthplace Annapolis, Md

MOTHER 14. Maiden name Eliza Bryan

15. Birthplace A-A. Co, Md

16. Informant Miss Katie Popham

Address King George St, Annapolis Md

17. Burial (Burial, cremation, or removal) Date thereof Dec 2, 1945 (month) (day) (year)

Cemetery or crematory St. Anne's

Location Annapolis, Md

18. Funeral director John M. Taylor & Son

Address Annapolis, Md

19. Dec 2 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1945 to Dec 29, 1945 and that I last saw h.. alive on Dec 29, 1945

Immediate cause of death	DURATION
Acute dilatation of the heart.	5 minutes
Due to	
Due to	
Other conditions Arteriosclerosis Cardio-Vascular disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert R. Anderson M.D. M. D. or other

Address Annapolis Md Date signed 12-31-45

10734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Neck
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: Annapolis Neck
How long in hospital or institution? ***************

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Neck R. F. D Box533
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis Neck
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Joshua Price

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	Married

6.(b) Name of husband or wife: Susie Price
6.(c) If alive, give age: ******** years

7. Birth date of deceased (mo., day, yr.): March 1886

8. AGE:	Years	Months	Days	If less than one day
	59	8		....hrs. ....min.

9. Birthplace: Anne Arundel Co. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: None

FATHER
12. Name: George Price
13. Birthplace: Anne Arundel Co.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Anne Arundel Co.

16. Informant: Mrs Susie Price
Address: Annapolis Neck

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/11/45 (month) (day) (year)
Cemetery or crematory: Annapolis Neck Cemetery
Location: Annapolis Neck

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Nov 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1945, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1944 to November 8 1945
and that I last saw h....alive on 1945

Immediate cause of death	DURATION
Apoplexy	
Due to: Hypertension	2 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Hendree E. Johnson M. D. or other
Address: 45 Northwest Street Date signed 11/

Dr Johnson

16735

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Arnold, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Arnold, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Ann Arundel

City or town: Arnold, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rosie Pulley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charlie Pulley

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): August 1880

8. AGE: Years	Months	Days	If less than one day
65	3		....hrs. ....min.

9. Birthplace: Arnold, Md. A.A.Co.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Fred Tooles

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Titis

15. Birthplace: Md.

16. Informant: Charlie Pulley, Arnold, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Arnold, Md.

18. Funeral director: J. F. Johnson

Address: Annapolis, Md.

19. Nov. 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24, 1945, at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/2/44 19.... to 11/24 19 45 and that I last saw h.. alive on 11/24/45 19....

Immediate cause of death	DURATION
Apoplexy	
Due to: Hypertension	1 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Johnson M. D. or other

Address: 40 Northwest Street Date signed: 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10736

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anna Arundel
City or town: Pasadena Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Life
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pasadena P. O.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Columbus D Richards.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Lillian
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 6-26-1918

8. AGE:

Years	Months	Days	If less than one day
27	4	7	hrs. min.

9. Birthplace: Anna Arundel County Md (Town, county and state)
10. Usual occupation: Chauffeur
11. Industry or business
FATHER 12. Name: Hernan Richards
13. Birthplace: Md
MOTHER 14. Maiden name: Sarena ?
15. Birthplace: Md
16. Informant: Sarena Richards
Address: Pasadena Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11 3 45 (month) (day) (year)
Cemetery or crematory: Magothy Cemetery
Location: Anna Arundel County Md
18. Funeral director: William A Jackson
Address: 916 Penna ave
19. 11-4 19 45 L. A. Blair
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 45 19 at 4 15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22-45 19 to Nov 2-45 19 and that I last saw h alive on Oct 29-45 19

Immediate cause of death	DURATION
Acute Cardio Renal Failure	1 Mo.
Due to	
Due to	
Other conditions: Advanced Pulmonary Tuberculosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Edgewood Md Date signed Nov 4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10737

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 19 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1526 North Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: SAUNDERS - ALBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Martha Saunders, 1526 N. Carey St., Baltimore
6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1868 ?

8. AGE: Years: 77 ? Months: unknown Days: If less than one day: ----- hrs. ----- min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 3, 1945 (month) (day) (year)
Cemetery or crematory: Arbutus Cemetery
Location: Baltimore County
18. Funeral director: George G. Kelson
Address: 1303 Presstman St., Balto., Md.
19. 12/30/1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 19 45 at 10:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10 1945, to Nov. 29 1945
and that I last saw him alive on November 29 1945

Immediate cause of death: General Arteriosclerosis — DURATION: Known to us since 8/10/45
Due to: -------
Due to: -------
Other conditions: Senile Psychosis — Known to us since 8/10/45
(Include pregnancy within 3 months of death)
Major findings of operations: -------
Date of op. -----
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of -----
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -------
Means of injury ------- Injured at work? -------

23. SIGNATURE: Wm. V. Hutchcroft M. D. or other
Address: Crownsville, Maryland Date signed 11/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

10738

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEceased:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George M. Shubert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Emma V. Shubert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 27, 1863

8. AGE: Years 82 | Months 6 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Friendship, A.A. Co., Md
(Town, county, and state)

10. Usual occupation farmer (retired)

11. Industry or business

FATHER 12. Name George Shubert
13. Birthplace A.A. Co, Md

MOTHER 14. Maiden name Katherine Atwell
15. Birthplace A.A. Co., Md

16. Informant Mrs. Louis N. Phipps
Address College Ave, Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15, 1945 (month) (day) (year)

Cemetery or crematory Cedar Grove
Location Deale, Md

18. Funeral director John M. Taylor & Son
Address Annapolis, Md.

19. Nov 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13, 1945, at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 22 1945 to Nov 13 1945 and that I last saw h... alive on Nov 12 1945

	DURATION
Immediate cause of death Uraemia	48 hrs.
Due to Ca. Interstitial Nephritis	Several yrs.
Due to Arterial Hypertension & Arteriosclerosis	Several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Oliver Parris
M. D. or other
Address Annapolis Md Date signed 11/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10739

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 1903
Hospital, institution, or street address where death occurred: 113 South St. Annapolis Md.
How long in hospital or institution? ********************

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. 113 South St. (If rural, give LOCATION)
2.(a) If veteran, name war: World War 1

3. (a) FULL NAME: Charles Henry Simms
3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Susie Simms
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.): July 8. 1899

8. AGE: Years	Months	Days	If less than one day
46	4	11	......hrs. ......min.

9. Birthplace: Harwood Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: None

FATHER
12. Name: James Simms
13. Birthplace: West River Md.

MOTHER
14. Maiden name: Florence E. Molden
15. Birthplace: Bristol Md. A. A. Co.

16. Informant: Mrs Florence E. Simms
Address: 72 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/ 23/ 45 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: West St extd. Annapolis Md.
18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St Annapolis Md.

19. Nov 23 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20 1945, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; Post mortem Examination ~~and that I last saw h... alive on~~ Nov. 20 1945

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Coronary Sclerosis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...... Date of op. ......
Autopsy results: ......

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of ......
Where did injury occur? ...... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury ...... Injured at work? ......

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis Md Date signed: 11/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

10740

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Dorsey Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A A.
City or town: Dorsey Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thos Kelly Simms

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Mamie Simms
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.): Nov 26 1869

8. AGE: Years	Months	Days	If less than one day
75	11	29	hrs. min.

9. Birthplace: Anne Arundel (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Henry Simms
13. Birthplace: A. A Co.
MOTHER 14. Maiden name: Esther Thomas
15. Birthplace: A A Co.
16. Informant: Herbert Simms
Address: Dorsey Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29 1945 (month) (day) (year)
Cemetery or crematory: St Marks
Location: Harmans Md
18. Funeral director: The W G White Co
Address: Laurel, Md.
19. Nov 29 1945 (Date rec'd by registrar) Clara Kastle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25th 1945 at 7.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27th 1945 to Nov. 25th 1945 and that I last saw h him alive on Nov. 25th 1945

Immediate cause of death	DURATION
(a) Myocarditis	1 wk.
Due to: Hypertensive cardiovascular disease	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank Shipley, M.D. M. D. or other
Address: Savage, Md. Date signed 11/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (846)

10741

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)
Street No. ------ (If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: SMACK - JOHN ALBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE: Years: 33 Months: unknown Days: If less than one day: --- hrs. --- min.

8. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----

FATHER — 12. Name: John Smack
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Henrietta Brittingham
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 7 1945 (month) (day) (year)
Cemetery or crematory:
Location: Berlin, Md
18. Funeral director: John W. Burbage
Address: Berlin, Md.

19. Nov. 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1945 at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 1945 to Nov. 3 1945 and that I last saw him alive on November 3 1945

	DURATION
Immediate cause of death: Schizophrenic Exhaustion	
Due to: Schizophrenia	Known to us since 10/20/45
Due to: --------	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op. ----
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of ----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ---------- Injured at work? -----

23. SIGNATURE: Herbert V. Whitehead M. D. or other
Address: Crownsville, Maryland Date signed: 11/3/45

J. B. Johnson
Annapolis, Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

10742

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Anne Arundel

1. PLACE OF DEATH:
County Annapolis Md.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 316 First St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward D. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Agnes M. P. Smith
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18th 1884

8. AGE:

Years	Months	Days	If less than one day
61	4	14	hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation Watchman U.S. Naval
11. Industry or business Academy Annapolis Md.
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Agnes M. P. Smith
Address 316 First St. Eastport Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4th 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John W. Taylor & Son
Address Annapolis Md.
19. Nov. 4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2, 1945, at 10.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1945, to Nov 2 1945
and that I last saw h... alive on Nov 2 1945

Immediate cause of death	DURATION
(a) Pulmonary Edema	1 Min.
Due to (b) myocardial infarct	24 hrs.
Due to (c)	
Other conditions	

Chr. Cardio Vascular disease Decomp. 2 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. J. Kavanaugh, M.D.
M. D. or other
Address 31 Southgate Ave Date signed 11/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10743

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 15

1. PLACE OF DEATH:
County a a
City or town Gambrills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39
Hospital, Institution, or street address where death occurred:
Gambrills
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County a a
City or town Gambrills
(If ontside city or town limits, write RURAL and give neareat town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Winfield Henry Smith

3.(b) Social Security Number 212-16-5362

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Elizabeth Hook Smith
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec 17 — 1885

8. AGE: Years	Months	Days	If less than one day
59	7	21	....hrs. ....min

9. Birthplace Millersville, Md.
(Town, county, and state)
10. Usual occupation Electrical worker
11. Industry or business

FATHER
12. Name Henry R. Smith
13. Birthplace Md

MOTHER
14. Maiden name Mary E Saunders
15. Birthplace Maryland

16. Informant Mrs Elizabeth H. Smith
Address Gambrills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 10/45 (month) (day) (year)
Cemetery or crematory Baldwin memorial
Location Millersville - Md.

18. Funeral director B. L. Hopkins
Address Annapolis Md

19. 11/10 1945 E. Jaye Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8. 45 3.55 P. M. 19.... at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1-45 19.... to Nov 8-45 19.... and that I last saw h.... alive on Nov 7-45 19....

Immediate cause of death	DURATION
Coronary Thrombosis	3 hrs.
Due to	
Due to	
Other conditions Arteriosclerosis	8 mo.

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....
Antopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. G. Lyons M. D. or other
Address Glenburnie Md Date signed 11-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
NOV 14 1985

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10744

28

Reg. Diat. No.

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years, 11 months, 8 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 years, 11 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ------

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no home
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: SPENCER - GEORGE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	unknown

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1872 ?

8. AGE: Years: 73 ? Months: unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which?: burial Date thereof: 12/10-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt Hospital
Address: Crownsville

19. 12-10 1945 (Date rec'd by registrar) E7 Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30 1945, at 8:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 1942, to Nov. 30 1945 and that I last saw him alive on November 30 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 12/31/42
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op.: -----

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -------

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ------- Injured at work? -------

23. SIGNATURE: Albert J. Stinebrickner M. D. or other

Address: Crownsville, Maryland Date signed: 11/30/45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

10745

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Madison St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph W. Wayson

3.(b) Social Security Number 219-01-8947

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 10 1901

8. AGE: Years	Months	Days	If less than one day
44	1	13	..... hrs. ..... min.

9. Birthplace maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Albert L. Wayson

FATHER 13. Birthplace maryland

MOTHER 14. Maiden name Annie M. Carrick

MOTHER 15. Birthplace maryland

16. Informant Albert L Wayson

Address 48 Madison St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25 45 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md.

18. Funeral director B. L. Hopkins

Address Annapolis Md

19. Nov. 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1945, at 4 50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945, to Nov 23 1945 and that I last saw h.. alive on Nov 22 1945

Immediate cause of death	DURATION
Myocarditis Chr.	4 yrs.
Myocardial Insufficiency	4 yrs.
Due to Hypertension	4 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Geo. C. Basil M. D. or other

Address Annapolis Md Date signed Nov 24 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

10746

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 Cumberland Court.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marguerite Darrieulat Weidmann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Martin Weidmann

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 23d 1862

8. AGE: Years: 83 | Months: 4 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Dax France
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Jean Darrieulat
13. Birthplace: Dax France

MOTHER
14. Maiden name: Marie Darricau
15. Birthplace: Dax France

16. Informant: Mrs Yvonne E. Haines
Address: Cumberland Court Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 6th 1945 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington D C

18. Funeral director: John W. Taylor & Son

Address: Annapolis Md

19. Nov. 5 1945 (Date rec'd by registrar) Mrs Donnelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 3 1945, at 4.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to Nov 3 1945

and that I last saw h[illegible] alive on Nov 3 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Nov 1st
Due to: Hypertension	[illegible]
Due to: Arteriosclerosis	
Other conditions: Chr. Lymphatic Leukemia	[illegible]

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. C. Boswell M. D. or other

Address: Annapolis Md Date signed 11-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1640)

10747

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ferry Farms
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ferry Farms
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice Virginia Welch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George W. Welch
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 4th 1911

8. AGE: Years	Months	Days	If less than one day
34	0.	1	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: Charles H. Whitlock
13. Birthplace: Va
MOTHER 14. Maiden name: Lorie Jeffries
15. Birthplace: North Carolina
16. Informant: Geo W. Welch
Address: Ferry Farms A A Co Md.
17. Buried
(Burial, cremation or removal. Which?) Date thereof Nov 6th 1945 (month) (day) (year)
Cemetery or crematory: Oakwood Cemetery
Location: Richmond Va
18. Funeral director: Henry W. Woody
Address: 700 N 25th St Richmond Va
19. Nov. 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1945 about 7 A.M
21. I CERTIFY that death occurred ~~on the date~~ above stated; ~~that I attended deceased from~~ Postmortem & Examination
~~and that I last saw h~~ alive on Nov. 5 1945

Immediate cause of death	DURATION
Strangulation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of Nov. 5, 1945
Where did injury occur? Ferry Farms (City or town) Anne Arundel (County) Maryland (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury: hanging by neck to tree with rope. Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 11-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

CERTIFICATE OF DEATH

10748

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Ferry Farms
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Ferry Farms
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Barbara Irene Welch (EILEEN ~~Irene~~ birth cer. 9-27-45)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 27th 1945

8. AGE:

Years	Months	Days	If less than one day
	1	9	... hrs. ... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George W. Welch

13. Birthplace Penn. Whitlock

MOTHER 14. Maiden name Alice Virginia ~~Baker~~

15. Birthplace Virginia

16. Informant George W. Welch
Address Ferry Farms A A Co Md

17. Remove (Burial, cremation, or removal. Which?) Date thereof Nov 6 1945 (month) (day) (year)

Cemetery or crematory Oakwood Cemetery

Location Richmond Va

18. Funeral director Henry W. Woody

Address 700 N. 25th St. Richmond Va

19. Nov 6 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1945, at 7 A.M. (about 30)

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination ~~to~~ ~~and that I last saw him alive on~~ Nov. 5 1945

Immediate cause of death	DURATION
Asphyxiation	
Due to	
Sulphur Dioxide Gas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of Nov. 5 1945
Where did injury occur? Ferry Farms, Anne Arundel, Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury punctured Coal in refrigerator Injured at work? Deputy ~~Medical~~ Examiner

23. SIGNATURE Lee M. Claffey M.D. M. D. or other
Address Annapolis, Md. Date signed 11-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

10749

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ferry Farms

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Ferry Farms

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ellen Lorine Welch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 5th 1943

8. AGE: Years: 2 Months: 10 Days: If less than one day: hrs. min.

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: George W. Welch

13. Birthplace: Penna.

MOTHER — 14. Maiden name: Alice Virginia Whitlock

15. Birthplace: Virginia

16. Informant: George W. Welch

Address: Ferry Farms A A Co Md

17. Burial, cremation, or removal. Which?: Removal Date thereof: Nov 6th 1945 (month) (day) (year)

Cemetery or crematory: Oakwood Cemetery

Location: Richmond Va

18. Funeral director: Henry W. Woody

Address: 700 N. 25th St. Richmond Va

19. Nov. 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1945 at about 7:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Post Mortem Examination to Nov. 5 1945 and that I last saw h— alive on

Immediate cause of death	DURATION
Asphyxiation	
Due to: Sulphur Dioxide Gas	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: Nov. 5 1945

Where did injury occur?: Ferry Farms (City or town) Anne Arundel (County) Maryland (State)

Injured at home, farm, Industry, public place (where?): at home

Means of injury: puncture Coil in repe Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis Md Date signed: 11-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

CERTIFICATE OF DEATH

10750

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 20 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 7 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion Station
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ---
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: WHITTINGTON - OLIVIA MAE

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): March 8, 1929

8. AGE: Years	Months	Days	If less than one day
16	7	28	--- hrs. --- min.

9. Birthplace: Marion Station, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: ----

FATHER — 12. Name: Council Whittington

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Stella Lankford

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: nov 9 1945 (month) (day) (year)

Cemetery or crematory: Branch

Location: marion md

18. Funeral director: Chas H ward

Address: marion md.

19. Nov 8 1945 (Date rec'd by registrar) E. Joyce Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 1945, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1945 to Nov. 6 1945 and that I last saw her alive on November 6 1945

Immediate cause of death: Epilepsy — DURATION: Known to us since 3/16/45

Due to: ---

Due to: ---

Other conditions: Idiot

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert V. Mackrodt M. D. or other

Address: Crownsville, Maryland Date signed: 11/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117a

10751

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Bar Harbor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Bar Harbor

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Bertie Wilt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	marr

6.(b) Name of husband or wife Garland Wilt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 5, 1893

8. AGE: Years	Months	Days	If less than one day
52	8	21	..... hrs. ..... min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name .....

15. Birthplace "

16. Informant Sherman M. Wilt

Address Bar Harbor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/29/45 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Ritchie Highway

18. Funeral director John F. Denny, Inc.

Address 715 Light St.

19. 11/28/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1945, to Nov 26 1945

and that I last saw h.. alive on Nov 26 1945

Immediate cause of death	DURATION
Hemorrhage from perforated ulcer of Stomach	2 days
Due to Chronic ulcer	One year
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thos. H. Phillips M. D. or other

Address 1939 Edmondson Ave Date signed Nov 27 '45

Dr Phillips
1939 Edmondson Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

10752

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1417 West Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 1417 West Street (If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Jacob Wohlgemuth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian M. Wohlgemuth

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27, 1892

8. AGE:

Years	Months	Days	If less than one day
53	5	19	hrs. min.

9. Birthplace: Westminister, Md. (Town, county, and state)

10. Usual occupation: Clerk - Wildabrandt Store

11. Industry or business: U.S.N. Academy

FATHER

12. Name: Jacob P. Wohlgemuth

13. Birthplace: Germany

MOTHER

14. Maiden name: Annie M. Bernstein

15. Birthplace: Germany

16. Informant: Mrs. Lillian M. Wohlgemuth

Address: 1417 West St. - Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluffs

Location: Annapolis, Md.

18. Funeral director: John M. Taylor Funeral Home

Address: Annapolis, Md.

19. Nov. 18 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16th 1945 at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1945 to Nov 16 1945 and that I last saw him alive on Nov 16 1945

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden

Due to: Coronary Thrombosis — DURATION: about 1 hr.

Due to: Internal Hypertension — DURATION: many yrs.

Other conditions — DURATION: several yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other

Address: Annapolis Md. Date signed 11/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10753

Reg. Diat. No. 2 3

1. PLACE OF DEATH:
County: Millersville 99 Co.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 3 yrs
Hospital, institution, or street address where death occurred: Millersville 9.9. Co Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Agnes D. Wood

3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of husband or wife: James W Wood
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 4 - 7 - 1874

8. AGE: Years: 71 Months: 6 Days: 22 If less than one day: hrs. min.

9. Birthplace: Calvert Co Md (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: Joseph D Norfolk
FATHER 13. Birthplace: Calvert Co Md
MOTHER 14. Maiden name: Martha E Buckler
MOTHER 15. Birthplace: Calvert Co Md.
16. Informant: Mary E Stevens
Address: Crownsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2 1945 (month) (day) (year)
Cemetery or crematory: Mt Harmony
Location: Calvert Co Md.
18. Funeral director: Hutchins & Sons
Address: Owings Md
19. 11/30/1945 (Date rec'd by registrar) M Deale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29-45 19 at 10 30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1-45 19 to Nov 29-45 19 and that I last saw h alive on Nov 25-45 19

Immediate cause of death	DURATION
Lobar Pneumonia.	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: Date signed Nov 30 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10754

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83 (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: 12 Murray Avenue
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Murray Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Elizabeth C. Woolley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George E. Woolley
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): December 18, 1863

8. AGE: Years: 81 | Months: 11 | Days: 29 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Annapolis - R.C.A.S., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Charles D. Russell
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Jane B. Mitchell
15. Birthplace: Annapolis, Maryland

16. Informant: George E. Woolley
Address: Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: November 20, 1945 (month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Annapolis, Maryland

18. Funeral director: James M. Taylor & Son
Address: Annapolis, Md.

19. Nov. 20, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945, to Nov. 18, 1945
and that I last saw h alive on Nov. 17, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 Month
Due to: Hypertension	Unknown
Due to:	
Other conditions: Cystitis, Pelvis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: George E. Bunk, M. D. or other
Address: Annapolis, Md. Date signed: 11-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15